Submitted by
Rep. Meadows

DEPARTMENT OF
Management & Budget

Health Care Trust

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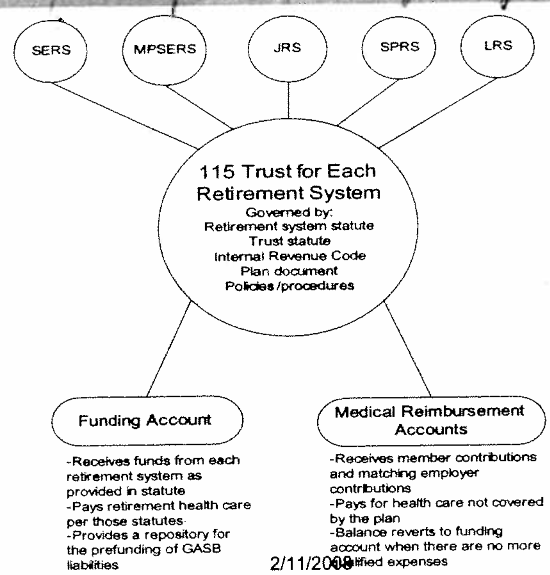
Office of Retirement Services
February 11, 2008

Purpose

- To prefund postretirement health benefits for new public employees in Medical Reimbursement Accounts.
- To create a repository for prefunding our GASB liabilities for existing employees.

115 Governmental Trust Framework



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Section 115

- Section 115 of the IRC allows governmental employers to establish and contribute to an irrevocable trust for prefunding retiree health care on a tax-free basis.

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Governance

- Statutory amendments would establish a section 115 trust for each system and set terms for participating and contributing.
- Retirement board members would act as trustees.

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Three Accounts Within the Trust

- Funding Account
  - Receives funds and pays for health care as provided by retirement statute and
  - Serves as a repository for funding our GASB liabilities
- Medical Reimbursement Accounts (MRAs) – individual accounts that pay for health care not covered by the plan

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MRAs - Eligibility

- Members and qualified participants of all five retirement systems could participate
- Employees first hired on or after July 1, 2008 would participate on a mandatory basis
- Those hired prior to July 1, 2008 could elect to participate on a post-tax basis

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MRAs - Contributions

Oct.

- Employees hired on or after ~~7~~/1/2008:
  - Mandatory pre-tax salary reduction contribution
    - Percentage determined by each retirement system's statute
  - Mandatory pre-tax employer contribution
    - Percentage determined by each retirement system's statute
  - Optional post-tax contributions
    - Elected on an individual level, up to 5% in increments of 1%

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MRAs - Contributions

- Employees before 7/1/2008:
  - Optional post-tax contributions
    - Elected on an individual level, up to 5% in increments of 1%

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MRAs - Payouts

- Participants become eligible for reimbursement of health costs upon termination of employment.
- If the individual and dependents die before account balance is drawn down to zero, the balance reverts to the trust in accordance with federal law.
- Qualified payouts are exempt from federal income tax.

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Advantages

- Provides Defined Contribution alternative to cash funding
  - Employer/employee share costs
  - Funds accrue to pay for future expenses
  - Assets generate investment income

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Advantages

- Provides a vehicle for prefunding health care that meets GASB standards
  - Separate legal entity protects assets for exclusive benefit of participants
  - Reduces liability by increasing assumed investment return
- Sustainable, scalable employer cost management
  - Fixed contribution rate
  - Assets can be used to replace or supplement insurance subsidies

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Office of Retirement Services

Serving more than 580,000 customers

July, 2007

Highlights

- Office of Retirement Services
  - Serves 1 out of every 18 Michigan residents
    - Public Schools, State Employees, State Police, Judges
  - Provided $4.7 billion in pension and health benefits in 2006
  - Current market value of the defined benefit plan's assets total more than $55 billion

Retirement Policy

- Good public policy to promote financial security in retirement
- Health care is a vital component of financial security in retirement
  - In 2006 the national average monthly cost for a pre-Medicare individual to purchase health care was $552.00 and $363.50 for a Medicare member.

SOURCE Kaiser Family Foundation and Hewitt Associates December 2006

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National Health Expenditures 2005

- $2 Trillion in Total Expenditures
- $6,700 per capita (all age groups)
- 16% of GDP
- Increase of two times the rate of inflation from 2000-2005

SOURCE: National Coalition on Health Care

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Health Care Cost Drivers

- Aging of the population
  - Additional retirees
- More health services available
  - Continued technology advances (including drugs)
  - Growing consumer demand for newest, best treatment
  - Health insurance masks true cost of care

Health Care Cost Drivers

- Health Care Delivery System
  - Lack of Evidence-Based Medicine
  - Indirect costs associated with the uninsured
  - Retreat from managed care

Highlights

Michigan Public School Employees' Retirement System

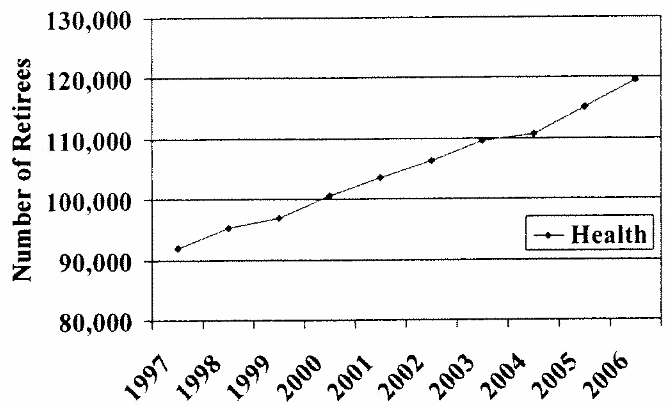
- Members include employees of public schools, community colleges, and seven universities*
- Statewide retirement system that provides retiree pension and health benefits

*Central Michigan, Eastern Michigan, Western Michigan, Northern Michigan, Ferris State, Lake Superior State, and Michigan Technological Universities (closed to new members on or after January 1, 1996)

Health Plan Demographics

- Michigan Public School Employees' Retirement System Provides
  - Comprehensive medical and drug coverage
  - 65% are over age 65
  - 60% Female, 40% Male

Retirees Receiving Benefits



3.5% annual increase

SOURCE: State of Michigan Comprehensive Annual Financial Reports

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What the Plan Provides

- Health Care – PPO (Non-Medicare) and Medicare Advantage (Medicare)
  - Medical
    - Comprehensive hospitalization
    - $250 deductible
    - 10% coinsurance
    - $500 out of pocket maximum
  - Drug
    - Consumerism Incentives
      - Generics
      - Lowest cost setting
      - Formulary
    - 20% copayments with $7 min/$32 max retail
    - $800 out of pocket maximum
- Dental and Vision

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Health Care Costs

- What can we expect
  - Costs will increase due to more retirees and medical inflation (cost drivers)
- Background
  - 1975
    - The plan was enacted and fully insured; no quality and cost management
  - Mid 1980s:
    - Costs began to rise rapidly

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Health Care Costs

- Background (cont'd)
  - Early 1990s:
    - Costs continued rapid rise with Michigan in a budget crisis
    - No established goals or guidelines
    - Prior to the 1990s Board actions had only been cost sharing increases
- It was understood that
  - There would be advances in heath care and the Board wanted to take advantage of them
  - Schools have limited budgets so goals must reflect the presumed growth in their revenues

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Health Care Costs

- The Solution
  - Early 1990s:
    - Plan became self-insured
    - Adopted a formal strategic planning process
      - Established Goals
      - Identified Options
      - Mechanism to Monitor Options
    - To identify, advance and monitor initiatives with a guiding mission:

Health Care Costs

Established Goals

- Provide a high quality health care plan that is affordable to both the members and the schools
  - Quality Goal "Measurably improve the quality of care enjoyed by members"
  - Cost Goal "Limit the rate of cost growth to the compound rate of inflation (CPI) and real economic growth."

Health Care Costs

Examples:

- 1994
  - Implemented the Managed Prescription Drug Program
    - Preferred Pharmacy Providers
    - Mail order Pharmacy
    - Generic substitution
- 1995
  - Implemented Cardiac Centers of Excellence program
  - Began utilizing national BCBS network for processing out-of-state claims

Health Care Costs

Examples (cont'd):

- 1998
  - BCBSM established a Nurse Health Information service called Blue Healthline
  - HMO Pilot program introduced
- 2000
  - Increased comprehensive Deductible to $165 single, $330 family
  - Drug co-pay changed to 20% of approved amount, $4 minimum and $20 maximum at retail, $10 and $50 max for a 90-day supply

Health Care Costs

Recent Examples:

- Public School Retirement System plan design (Prescription Drug program, Nurseline, and Cost Sharing) updates have resulted in savings of $150 million since 2000, while maintaining access and quality.
- Implementation of Medicare Prescription Drug Plan which saved $80 million in 2006 and 2007 and Medicare Advantage which is projected to save an additional $40 million in 2007.

Funding Health Care Costs

- Public School Health Care Contribution
  - Is a percent of payroll based on expected health care costs for the upcoming year
  - Pay-as-you-go system
  - Health care costs are unrelated to payroll

Health Care Costs

- What we have done
  - Implemented plan design changes to keep the contribution rate to the school flat at 6.55% for 4 years.

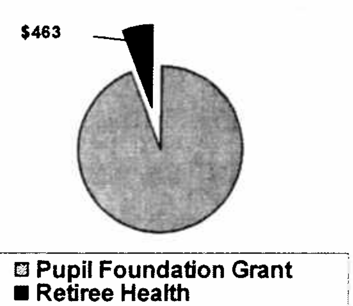
Fiscal Year	Annual Costs	Contribution Rate
2001	$498 M	5.55%
2002	$558 M	6.05%
2003	$607 M	6.05%
2004	$667 M	6.05%
2005	$762 M	6.55%
2006	$694 M	6.55%
2007		6.55%
2008		6.55%

SOURCE CAFR

Health Care and the Foundation Grant

- The State and schools experiencing severe budget problems
- $463 of the current $7,075 per student foundation grant goes towards retiree health care

Health Care Effects on Schools



FY 2007

The Questions

- Is health care coverage a critical component of encouraging and retaining quality personnel?
  - If so, how will the increasing cost of coverage be paid?
  - If not, how might coverage be changed?
- How can all stakeholders (employees, retirees, employers, policy makers) get to consensus?
- Governmental Accounting Standards Board (GASB)? (Increased focus on retiree health care)

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GASB

- GASB requires governmental entities to report their Other Post Employment Benefits (OPEB).
  - Benefits other than pensions earned by employees over their years of service that will not be received until after their separation of employment with the government.
    - i.e.:Health, Dental, Vision, Life, etc.

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GASB

- Reporting the potential long term liability in the comprehensive annual financial reports since 1999.
  - Will be officially reported in 2007 in compliance with GASB.
  - Does not create a new liability

Public Schools - Health

- Annual costs = $694 million
- Potential Unfunded Liability = $13.2 billion
- Current Employer Contribution Rate (2006-2007) = 6.55%

Potential Unfunded Liability from September 2006 valuation and Annual Cost from 2006 CAFR

State Employees – Health Fund

- Annual Costs = $363 million
- Potential Unfunded Liability = $7.5 billion
- Current Employer Contribution Rate (2006-2007) = 12.20%

Potential Unfunded Liability from September 2006 valuation and Annual Cost from 2006 CAFR

What Can Be Done?

- Continued Plan Management
  - Incremental actions
    - Cost avoidance
      - Avoiding, or reducing the severity of illnesses
        - » Care Management Programs
      - Shifting the costs to another party through Coordination of Benefits
        - » Medicare Advantage
    - Cost reduction
      - While they may be inconvenient, they are designed so that they do not increase (and sometimes reduce) member costs
        - » Drug Program Formulary
    - Cost sharing
      - Balance between what members pay and what the System pays
        - » Deductibles
- Eligibility
  - Who and When
  - Years-based premium subsidy
- Reduce Benefits

What Can Be Done?

- Tackle long term funding
  - Raise Revenue
- Do Nothing – wait for a national solution
  - Risks Include:
    - Population growth
    - Unmanaged cost increases
    - Michigan may end up bearing the costs (Medicaid and Uninsured)

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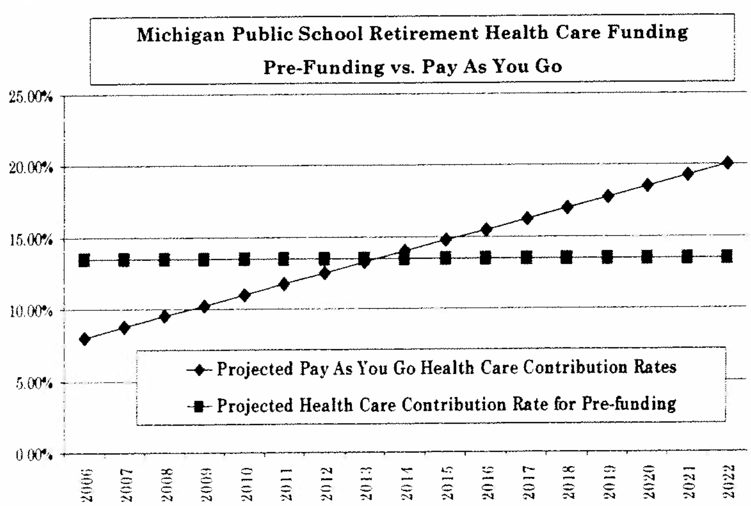
What Can Be Done?



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What Can Be Done?

- Can employers begin paying more now to stabilize health costs?
  - $13.5 billion potential unfunded liability
    - Projected 13.5% of pay for 30 years
  - Can we get an additional 7% of pay over a period of years?
    - 1% per year?
  - Should active employees contribute?
  - Years-based premium subsidy (graded premium)?

SOURCE: Annual Valuation

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Conclusions

- Pension costs have increased in the past few years but are stabilizing as the markets remain strong
- Health care costs will continue to increase
- Providing health care coverage to retirees is good public policy
  - Ultimately someone is going to bear the cost
  - Component of encouraging and retaining quality personnel

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Next Steps

- Tackle part of the plan's unfunded liability
- Be engaged at the national level
- Assess progress in two years and adjust

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